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Issue Date: 03 August 2005

In the Matter of:

CHARLES A. MORGAN,
Claimant,

CASE NO: 2003-BLA-6375

v.

SHAMROCK COAL COMPANY,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:

Edmond Collett, Esquire
For the Claimant

Lois A. Kitts, Esquire
For the Employer

Before: Edward Terhune Miller,
Administrative Law Judge

DECISION AND ORDER – REJECTION OF CLAIM

Statement of Case

This proceeding involves an initial claim for benefits under the Black Lung Benefits Act (Act) as amended, 30 U.S.C. §§ 901 *et seq*. Claimant filed his claim after January 19, 2001. The claim is therefore governed by 20 C.F.R. Part 718 (2004).[1] Because Claimant last worked in

[1] All references to the Code of Federal Regulations are by part or section under Title 20 unless otherwise indicated. Claimant's exhibits are denoted "C-"; Employer's, "E-"; and the Director's, "D-"; references to the transcript of hearing are denoted "Tr."

Kentucky, the claim is subject to the law of the United States Court of Appeals for the Sixth Circuit. *Shupe v. Director*, *OWCP*, 12 BLR 1-202 (1989) (en banc).

Issues

1. Whether Claimant has pneumoconiosis.
2. Whether Claimant's pneumoconiosis, if proved, was caused by his coal mining employment.
3. Whether Claimant has proved that he is totally disabled.
4. Whether such disability, if proved, was caused by Claimant's pneumoconiosis.

Procedural History

Claimant, Charles A. Morgan, filed his claim for benefits on December 12, 2001. (D-2). The District Director for the Department of Labor (DOL) denied benefits in a Proposed Decision and Order dated May 12, 2003, because Claimant did not establish that he had pneumoconiosis, that it was caused, at least in part, by coal mine work, or that he is totally disabled by the disease. (D-29). The District Director designated Shamrock Coal Co. Inc. (Employer) as the Responsible Operator liable for the payment of any black lung benefits. *Id.* That designation is not contested. (Tr. 8).

The Director sent notice of its designation as the Responsible Operator to Employer on November 15, 2002. (D-19). Following the District Director's denial of benefits, Claimant filed a timely request for a formal hearing, which was conducted on July 26, 2004 in Hazard, Kentucky. Claimant was represented by counsel. Employer appeared by counsel. (Tr. 5-6)

Background

Claimant was born April 4, 1953. (D-2; Tr. 11). His only dependent is his second wife, Henrietta, whom he married in 1975. (Tr.11; D-8). He is not obligated to support his former spouse. (D-2). Claimant has a twelfth grade education. (Tr. 11-12). Employer stipulated to at least twenty-five years of coal mine employment. (Tr. 8). Claimant's Social Security Earnings records and Claimant's testimony support a finding that Claimant worked as a coal miner for at least twenty-five years, all but the first three years underground. (D-6,5; Tr. 12-18). Claimant worked for the Respondent Employer from January 1978 to July 2001 as a bolter operator, repairman, and foreman. (D-3, 4, 5, 6). Claimant's coal mining work involved varied heavy manual labor, and extensive coal dust exposure. (Tr. 12-18). Claimant testified that he was a regular smoker for a couple of years in his early twenties, and thereafter has smoked an occasional cigarette. (Tr. 12).

Admissibility of Evidence Under Pertinent Regulations[2]

The Director offered Dr. Simpao's x-ray interpretation, pulmonary function studies, arterial blood gas studies, and medical report, all dated February 12, 2002, as Director's Exhibit

[2] This determination was reserved at the hearing. (Tr. 32).

10. That evidence is admissible as evidence generated by the mandatory pulmonary examination provided to Claimant of right under the applicable regulations. § 725.406. Claimant identified x-ray interpretations by Dr. Baker of films dated April 10, 2002, and May 31, 2003, pulmonary function studies, arterial blood gas studies, and a medical report by Dr. Baker all dated April 10, 2002, all of which are admissible as initial evidence under § 725.414(a)(2)(i). (D-11; C-4; C-A) Claimant also identified an x-ray interpretation by Dr. Alexander of a film dated March 7, 2002, as rebuttal of the interpretation by Dr. Rosenberg, and an x-ray interpretation by Dr. Alexander of a film dated February 12, 2002, as rebuttal of the interpretation by Dr. Simpao. (C-1, 2; C-A) Both interpretations are admissible as such.

Employer identified x-ray interpretations by Dr. Rosenberg of films dated June 14, 2004, and March 7, 2002, prebronchodilator pulmonary studies dated June 14, 2002, and pre- and post bronchodilator pulmonary function studies dated March 7, 2002, resting arterial blood gas studies dated June 14, 2004, and March 7, 2002, and a medical report by Dr. Rosenberg dated June 18, 2004, elaborated in Dr. Rosenberg's deposition taken July 15, 2004, as initial evidence, which is admissible as such under § 725.414(a)(3)(i). (E-1, 10; E-A). Dr. Rosenberg referred in his 2004 report and deposition to his earlier examination of the Claimant and resulting report dated March 7, 2002, which was not separately identified as admissible evidence. Since that report was used by Dr. Rosenberg primarily as a benchmark to evaluate changes in Claimant's condition, was an inherent part of the relevant medical record which was part of a continuum of his medical evaluation, because the references apparently were not outcome determinative, and since there was no specific objection, the reference is determined not to render Dr. Rosenberg's 2004 report inadmissible or to disqualify it from appropriate consideration under § 725.414. Employer also identified the medical report of Dr. Broudy dated June 24, 204, as initial evidence, properly admissible as such. (E-8; E-A).[3]

In addition, Employer identified two x-ray interpretations by Dr. Poulos of films dated April 10, 2002, and May 31, 2003, as rebuttal of the interpretations of those films by Dr. Baker, which are admissible as such under § 725.414(s)(3)(ii). (D-13; E-3). Employer identified an x-ray interpretation by Dr. Halbert of a film dated February 12, 2002, as rebuttal of the interpretation by Dr. Simpao, which is admissible as such. Employer identified reports by Dr. Vuskovich dated June 18, 2004, as rebuttals of the pulmonary function and arterial blood gas studies performed by Dr. Baker on April 10, 2002, and Dr. Simpao on February 12, 2002, respectively. (E-7, 6; D-11, 10; E-A). Section 725.414(a)(1) provides, in part, that "[a] physician's written assessment of *a single objective test,* such as a chest X-ray or a pulmonary

[3] Respondent identified the medical report dated June 24, 2004, and qualifications of Dr. Broudy in the evidence summary form dated July 6, 2004, as one of the two medical reports comprising its initial evidence, but misidentified it as EX-9. (E-A) That medical report and Dr. Broudy's qualifications were physically included as part of Respondent's Exhibit 8, along with the qualifications of Dr. Vuskovich, which was identified and admitted into evidence at the hearing without objection except to the extent that they might exceed the evidentiary limitation in the applicable regulations. (Tr. 35-36). A duplicate copy of Dr. Broudy's medical report earlier submitted had just been returned to Respondent's counsel. (Tr. 32) And Dr. Broudy's medical report was referred to in Respondent's brief. (Respondent's. Br. At 5, 8-9, 11, 12). However, Respondent's counsel failed specifically to mention Dr. Broudy's medical report when she identified Respondent's evidence and requested admission of Employer's Exhibit 8 into evidence at the hearing. (Tr. 35). The omission is determined to be an oversight by counsel which is unintentional and nonprejudicial under the circumstances, and Dr. Broudy's medical report dated June 24, 2004, and professional qualifications are deemed to be properly admitted, as submitted, in evidence as E-8.

function test, shall not be considered a medical report for purposes of this section." (Emphasis supplied.) Since each of Dr. Vuskovich's reports contain assessments of two objective tests, i.e. a pulmonary function test and an arterial blood gas study, they technically would not qualify for the exemption in § 725.414(a)(1). However, since the reports could readily be divided into separate reports of single objective tests, which would serve no useful purpose other than hypertechnical compliance in this case, and which, as such, would be admissible, those reports of Dr. Vuskovich are deemed to be admissible intact as assessments of single objective tests under § 725.414(a)(3)(ii).

Medical Evidence

Chest X-Ray Evidence

Ex. No.	Physician	B-Reader /BCR[4]	Date of X-ray	Film Quality	Reading
D-11	Baker	None	4/10/02	1	1/0
C-4	Baker	None	5/31/03	1	1/0
D-10	Simpao	None	2/12/02	1	1/0
E-1	Rosenberg	B	6/14/04	1	0/0
E-1	Rosenberg	B	3/7/02	1	0/0
C-1	Alexander	B, BCR	3/7/02	1	1/0
C-2	Alexander	B, BCR	2/12/02	1	1/1
D-13	Poulos	B, BCR	4/10/02	1	0/0
E-3	Poulos	B, BCR	5/31/03	1	0/0
D-12	Halbert	B, BCR	2/12/02	1	0/0

Dr. Rosenberg, as the original interpreter of the x-ray film dated 3/7/02, whose interpretation was challenged by Dr. Alexander, included a responsive rehabilitative statement in his report dated June 18, 2004, which declared that the "p" opacities recorded by Dr. Alexander were not present, and that Claimant's "serial chest X-rays over the years are 0/0 for the presence of any micronodularity associated with past coal dust exposure." (E-1) Dr. Poulos, a B-reader and board-certified radiologist, reread the May 31, 2003, x-ray film, initially read by Dr. Baker, and included a narrative report which recorded that lung field were clear, there was a negative chest and no evidence of pneumoconiosis. (E-3, 4). Dr. Halbert, a B-reader and board certified radiologist, reread as negative the February 12, 2002, film read as positive by Dr. Simpao and Dr. Alexander. (E-5)

[4] "BCR" refers to a board-certified radiologist. "B" refers to a NIOSH-certified B-reader. B-reader qualifications are recorded on the B-reader list published on DOL's website. *List of Approved B-Readers* (June 21, 1999), *at* http://www.oalj.dol.gov/public/blalung/refrnc/bread3.htm. The board-certifications of physicians are listed by the American Board of Medical Specialties. *American Board of Medical Specialties*, *at* abms.org (last visited September 1, 2004). This tribunal has taken judicial notice of these resources if the qualifications of particular physicians are not otherwise of record. *See Maddaleni v. Pittsburg and Midway Coal Co.*, 14 BLR 1-135 (1990).

Pulmonary Function Tests[5]

Ex. No.	Doctor	Date of Study	Age	Ht.[6]	Conf.	Qual.	FEV_1	FVC	MVV	FEV1/ FVC	Coop./ Comp.
D-11	Baker	4/10/02	49	70"	Yes	No	3.10	4.89		63%	
D-10	Simpao	2/12/02	48	70"	Yes	No	3.41	5.04	89	68%	Good/ Good
E-1	Rosen-berg	6/14/04	51	70"	Yes	No	2.97	4.23	101	70%	Good

Employer introduced the report of Dr. Vuskovich, who is board-certified in occupational medicine, dated June 18, 2004, to rebut Dr. Baker's pulmonary function tests performed April 10, 2002. Dr. Vuskovich explained that the FVC and FEV1 values generated would be normal, but opined that the spirometry was not valid because of poor effort. He declared that available information was insufficient to support a reasoned opinion as to coal mine work capacity. (E-6; D-11) Employer introduced a second report of Dr. Vuskovich dated June 18, 2004, to rebut Dr. Simpao's pulmonary function tests performed February 12, 2002. Dr. Vuskovich opined that the spirometry was valid, and the results normal, and indicates that Claimant retains the respiratory capacity to perform previous coal mine employment or similar arduous labor. (E-7; D-10).

Blood Gas Studies

Ex. No.	Physician	Date of Study	Qual.	Altitude	Rest(R) Exer.(E)	PCO_2	PO_2	Comments	Qual.
D-11	Baker	4/10/02	Yes	0-2999	R	50.0	73.0		No
D-10	Simpao	2/12/02	No	0-2999	R	50.9	68.7	Normal	No
E-1	Rosen-berg	6/14/04	No	0-2999	R	44.5	87.9	Normal	No
E-1	Rosen-berg	3/07/02	No	0-2999	R	49.7	73.5	Normal	No

Dr. Baker assessed, "Mild resting arterial hypoxemia with moderate hypercarbia." Employer introduced the report of Dr. Vuskovich dated June 18, 2004, as an assessment in rebuttal of Dr. Baker's blood gas studies performed April 10, 2002, which explained that an aberrant pCO2 value indicated inaccurate test results and that the studies were invalid possibly as the result of defective equipment. (E-6; D-11). The basis for that observation is unclear, given the values of the other arterial blood gas tests of record. The studies are in any event nonqualifying. Employer introduced the report of Dr. Vuskovich dated June 18, 2004, as an assessment of Dr. Simpao's blood gas study performed February 12, 2002, concluding that the study results, though crude measures subject to variable influences, were normal, and that based on the particular test, Claimant probably had a pulmonary capacity for coal mine employment, even if

[5] No post bronchodilation test results are recorded..

[6] The height is indicated as recorded by each physician. The ALJ is required to resolve the height discrepancy contained in the record. *Protopappas v. Director*, *OWCP*, 6 BLR 1-221 (1983). An average of the reported heights produced a height of 70 inches, which is adopted.

he had simple coal workers' pneumoconiosis. (E-7; D-10). There is sufficient diversity from Dr. Simpao's assessment to qualify Dr. Vuskovich's assessment as rebuttal.

Physician's Opinions

Dr. Simpao

Dr. Simpao, who is board-certified in internal medicine and the subspecialty of pulmonary disease, examined Claimant for coal workers' pneumoconiosis on behalf of the U.S. Department of Labor (DOL) and issued a report on February 12, 2002 (D-10; C-1). He noted social, medical, and employment histories, the latter involving work as a bolter operator, repairman, and welder for the Respondent Employer from 1978 to 2001. He noted a smoking history of one and a half packs of cigarettes per day from 1972 to 1975, and only rare puffs or smokes thereafter, sundry maladies and symptoms, including heart disease and a myocardial infarction in 2000, long term productive cough and shortness of breath since 1996, and other breathing problems. He recorded numerous medications, and diagnostic test results including chest x-ray disclosing coal workers' pneumoconiosis, 1/0, small airway disease, normal arterial blood gases, and abnormal EKG.

Dr. Simpao's cardiopulmonary diagnosis was CWP 1/0, noting a related etiology, "Multiple years of coal dust exposure is medically significant in his pulmonary impairment," and explaining that the basis of the diagnosis was "findings on the chest x-ray, pulmonary function test and EKG along with physical findings and symptomatology." He noted a "mild impairment" in relation to Claimant's capacity to perform his last coal mine work, in relation to an assessment of the extent to which his diagnosis contributes to the impairment, and he attributed the pulmonary impairment to pneumoconiosis. He opined that Claimant does not have the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment because of "objective findings on the chest x-ray and pulmonary function test, EKG along with symptomatology and physical findings as noted in the report."

In connection with the spirometry, Dr. Simpao commented by way of interpretation, "Vital capacity and flow volume curve are normal. However the FEV1/FVC ratio are reduced along with midflows. This test indicates small airway disease." Dr. Simpao's FEV_1/FVC ratio is between Dr. Baker's lower ratio and Dr. Rosenberg's higher ratio, though neither of those doctors noted a significant abnormality. Dr. Simpao noted that there was no exercise arterial blood gas study "due to chest pain with exertion," but that the study results were normal.

Dr. Baker

Dr. Baker, who is board-certified in internal medicine and the subspecialty of pulmonary diseases, examined Claimant on April 10, 2002, for possible dust induced lung disease secondary to his coal mine employment, and provided a medical report dated April 10, 2002. Dr. Baker is board-certified in internal medicine with a board-certified subspecialty in pulmonary disease. (D-11). At the time he interpreted Claimant's x-ray, he was not a B-reader. A suggestion that Dr. Baker was Claimant's treating physician was insufficiently developed to prove a status which would have entitled Dr. Baker's opinion to predominant weight.

Dr. Baker recorded medical, social, and employment histories, noting twenty-seven and a half years in the mining industry with twenty-four years underground, involving shoveling the belt, operating equipment and working as a section boss., as well as two and a half years as a welder in a shipyard involving exposure to welding fumes and asbestos. He noted a two year smoking history of a pack of cigarettes per day ending twenty-six or -seven years prior to the exam. Dr. Baker noted six or seven years of breathing problems, aggravated by exertion and other exposures and irritants, as well as significant at night, daily productive cough and wheezing, and limited capacity to walk on level or upgrade. He noted multiple medications for various maladies, including two for breathing. Physical examination disclosed clear lungs without rales or wheezes, and no clubbing, cyanosis, or edema.

Diagnostic testing resulted in a positive chest x-ray interpretation of 1/0 coal workers' pneumoconiosis, normal prebronchodilator pulmonary function tests, and arterial blood gas studies interpreted as revealing mild resting arterial hypoxemia and moderate hypercarbia. Dr. Baker assessed a Class 1 impairment with the FEV1 and vital capacity being greater than 80% of predicted, based on Table 5-12, p.107, Chapter 5, Guides to the Evaluation of Permanent Impairment, Fifth Edition. Dr. Baker assessed a second impairment based on a provision in the guide stating that persons with pneumoconiosis should limit further exposure to the offending agent, thus implying that the patient is 100% occupationally disabled for work in the coal mining industry or similar dusty occupations.[7]

Dr. Baker recorded a diagnosis of coal workers' pneumoconiosis, ILO classification 1/0, based on abnormal x-ray and significant history of dust exposure. He diagnosed mild resting arterial hypoxemia with moderate hypercarbia, based on arterial blood gas analysis, and chronic bronchitis, based on history of cough, sputum production and wheezing. He attributed the pneumoconiosis to exposure to coal dust in the severance o[r] processing of coal based on x-ray evidence of pneumoconiosis and no other condition to account for the x-ray changes. He attributed the pulmonary impairment to exposure to coal dust in the severance o[r] processing of coal based on Claimant's long history of dust exposure and minimal smoking history with x-ray evidence of pneumoconiosis. He opined that any pulmonary impairment is caused at least in part, if not significantly so, by Claimant's coal dust exposure.

Dr. Broudy

Dr. Broudy, who is board-certified in internal medicine and the subspecialty of pulmonary medicine and a B-reader, reviewed specified medical evidence provided by Employer and produced a report dated June 24, 2004. (E-8). The review was directed to determine whether the medical evidence would support a conclusion that Claimant had coal workers' pneumoconiosis or any impairment which arose from inhalation of coal mine dust, Based upon his review of Dr. Simpao's and Dr. Baker's reports and objective diagnostic testing, the chest x-ray interpretations of Drs. Simpao and Baker, Dr. Halbert and Dr. Poulos, Dr. Alexander and Dr. Rosenberg, Dr. Broudy agreed with Dr. Rosenberg, concluding that the evidence indicates that Claimant did not have coal workers' coal workers pneumoconiosis, based on the negative

[7] Dr. Baker cited Section 5.8, p. 106, Chapter Five, Guides to the Evaluation of Permanent Impairment, Fifth Edition.

readings of films by three well qualified B-readers, virtually normal spirometric studies indicating no obstructive airways disease or any impairment arising from the inhalation of coal mine dust, and, implicitly, normal recent blood gas study results. He also concluded that Claimant clearly retains the respiratory capacity to perform the work of an underground coal miner or to do similarly arduous manual labor.

Dr. Rosenberg

Dr. Rosenberg, who is board-certified in internal medicine, pulmonary disease, and occupational medicine, reviewed specified medical records and examined Claimant on June 14, 2004, to determine whether he has coal workers' pneumoconiosis or any impairment arising from his coal mining employment and the inhalation of coal mine dust, including whether Claimant has the respiratory ability to perform his previous coal mining job or is otherwise disabled. (E-1, 2) Dr. Rosenberg had previously evaluated Claimant on March 7, 2002, and he reviewed and compared the results of his prior evaluation as an inherent part of developing his later opinion. His review of medical records included the evaluations of Dr. Simpao and Dr. Baker, the x-ray readings by Drs. Halbert, Poulos, Alexander and Baker.

Dr. Rosenberg noted medical, social, and employment histories, and conducted diagnostic tests including taking a chest x-ray, and performing pulmonary function and arterial blood gas tests, and an EKG. The histories noted were essentially consistent with those recorded by the other examining physicians. He noted a cigarette smoking history of three to four years in the 1970's of less than a pack per day, and a continuing occasional "puff" because his wife smokes. He noted various medical maladies requiring medication and other treatment, including colon surgery, and treatments for heart disease. He noted Claimant's work history as surface coal mine work from 1974 to 1977, and underground thereafter as an equipment operator, including scoop, bolter, shuttle car, miner, and operating belts, as well as rock dusting, and other heavy work, with little or no respiratory protection. He noted that Claimant had retired in November 2003, in the aftermath of his colon surgery, but that Claimant had various maladies, surgeries, cardiac catheterization, and a myocardial infarction at the time.

Dr. Rosenberg recorded that his current evaluation disclosed little change. Claimant's breathing was no worse, and his exercise capacity was similar, though he had gained weight, and his blood pressure had increased. In connection with the examination and testing, Dr. Rosenberg noted that the chest x-ray was compared and unchanged, and was interpreted as 0/0, indicating no micronodularity associated with past coal dust exposure, and contradicting the finding of "p" opacities by Dr. Alexander. He observed that the pulmonary function tests were essentially unchanged in two years and revealed no obstruction or restriction and reflected normal diffusing capacity and lung volumes. He declared that the normal diffusing capacity corrected for lung volumes, indicted that the alveolar capillary bed within Claimant's lungs is intact. Consequently, Dr. Rosenberg opined that the totality of the available information indicates that Claimant does not have the interstitial form of coal workers' pneumoconiosis (CWP). He noted that from a functional perspective, because Claimant does not have obstruction or restriction, has normal diffusing capacity, normal oxygenation, which had improved, but has a degree of hypoventilation related to obesity, he could perform his previous coal mining job or similarly

arduous types of labor. Dr. Rosenberg opined that Claimant does not have chronic obstructive pulmonary disease because his pulmonary function test result, FEV1/FVC ratio, is normal.

In his deposition taken July 15, 2004, Dr. Rosenberg elaborated on his qualifications, his examination procedures, pertinent symptoms, and the medical criteria for his conclusions. (E-9). He noted a twenty-seven year coal mine dust exposure history, a probably insignificant cigarette smoking history of three to four years, normal pulmonary function tests, normal diffusing capacity, improved arterial blood gas study results, normal gas exchange, clear lungs, and no significant respiratory impairment, restrictive or obstructive. (E-9 at 20-21). He attributed the markedly abnormal pO_2 value of Dr. Simpao's blood gas study as possibly related to Claimant's pain or other medications. Nevertheless, he opined that Claimant would retain the respiratory capacity to return to his previous job in and around the mining industry, or to a job requiring similar arduous manual labor. (E-9 at 21-22) Although other doctors had identified positive changes on x-ray, Dr. Rosenberg declared that with respect to the x-rays he reviewed there were no abnormalities. (E-9 at 23).

Discussion and Conclusions of Law

To be entitled to benefits under Part 718, Claimant must establish by a preponderance of evidence that (1) he has pneumoconiosis, (2) the pneumoconiosis arose from his coal mine employment, (3) he is totally disabled, and (4) the total disability is due at least in part to pneumoconiosis. *Gee v. M.G. Moore & Sons*, 9 BLR 1-4 (1986). In the present case, Claimant has not established that he has pneumoconiosis, that he has a totally disabling pulmonary impairment, or that he is totally disabled by pneumoconiosis. The claim for benefits must therefore be denied.

Existence of Pneumoconiosis by X-ray

The applicable regulations define "pneumoconiosis" as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising from coal mine employment." § 718.201(a). This definition includes both "clinical" and "legal" pneumoconiosis. *Id.* "Legal" pneumoconiosis is broader by definition than "clinical" pneumoconiosis and includes "any chronic lung disease or impairment and its sequelae arising out of coal mine employment." § 718.201(a)(2). The existence of coal workers' pneumoconiosis may be proved by conforming x-ray evidence, biopsy or autopsy evidence, which does not exist in this case, the invocation of certain presumptions described in §§ 718.304, 718.305, or 718.306, which are not applicable in this case, and by the finding of a physician exercising sound medical judgment, based on objective medical evidence and supported by a reasoned medical opinion. § 718.202.

Claimant has not established the existence of pneumoconiosis by a preponderance of the x-ray evidence. The three positive readings by Dr. Baker and Dr. Simpao, who lack any pertinent special qualifications for x-ray interpretation, are outweighed in probative value by the readings of the several other physicians who have such qualifications. Dr. Alexander's two positive readings are inconsistent, in that, though they were interpretations of x-rays taken less

than a month apart, he classified one as 1/0 and the other as 1/1; in addition, his reading of the x-ray which Dr. Simpao read as 1/0, was 1/1. Although Dr. Alexander is both a B-reader and a board-certified radiologist, which would entitle his interpretations to substantial weight, his interpretations of each of two x-rays are contradicted by the negative interpretations of Dr. Rosenberg, a B-reader and Dr. Halbert, a B-reader and board-certified radiologist. In addition, Dr. Poulos, a B-reader and board-certified radiologist, interpreted the two x-rays interpreted by Dr. Baker as negative, and Dr. Rosenberg read the most recent June 14, 2004, x-ray as negative without contradiction. Thus the x-ray evidence is at best in equipoise, or reflects a failure of proof of pneumoconiosis by x-ray because the qualifications of the negative readers equal or outweigh those of the positive readers.

The Existence of Pneumoconiosis and Total Disability by Reasoned Medical Opinion

Dr. Rosenberg's opinion is the most convincing of the several physicians' opinions of record. He is the most qualified of the several physicians, being board-certified in internal medicine, pulmonary disease, and occupational medicine. The basis for his conclusions is the most extensively reasoned and explained of record. His conclusions were based, not only on a review of admissible medical records pertinent to Claimant, but reflected two comprehensive examinations, one in March 2002, and one in June 2004, by Dr. Rosenberg himself, which included extensive objective testing, the latter being the most recent of record by more than two years. The assessment in his report was buttressed by a detailed explanation in his deposition of his methodology and rationale. Based on the categorically negative x-ray interpretations, unchanged normal pulmonary function tests reflecting neither obstruction or restriction, and blood gas tests reflecting normal diffusing capacity, Dr. Rosenberg opined that Claimant had neither interstitial coal workers' pneumoconiosis nor chronic obstructive pulmonary disease, and without regard to his other maladies, has the pulmonary capacity to perform his previous arduous coal mine job or other labor.

Dr. Broudy's more limited report, based on a review of admissible evidence, concluded that Claimant does not have coal workers' pneumoconiosis, and that he has the respiratory capacity to do arduous coal mine work, based on the negative x-rays, and virtually normal spirometric studies. Dr. Broudy's qualifications as a board-certified internist and pulmonary specialist as well as a B-reader justify giving his opinion, which tends to corroborate Dr. Rosenberg's, significant weight.

The opinions of Dr. Simpao and Dr. Baker are substantially less credible and persuasive than Dr. Rosenberg's on the instant record. Both Dr. Simpao and Dr. Baker are board-certified in internal medicine and pulmonary disease, but neither was a B-reader at pertinent times, and they examined Claimant two months apart in 2002. Both diagnosed coal workers' pneumoconiosis based upon their positive x-ray readings and the extended history of coal mine dust exposure. They established no special qualifications to interpret the x-rays, and their positive readings were contradicted by better qualified readers. Moreover their reliance upon positive x-ray readings is inconsistent with the conclusion of this tribunal that the existence of pneumoconiosis is not established by a preponderance of the x-ray evidence of record. Neither of their medical reports reflected an examination of Claimant's pertinent medical records. Their conclusions were not consistent with and do not reinforce each other. Dr. Simpao diagnosed

small airway disease based on the pulmonary function tests he conducted, but he recorded normal blood gases and only a mild impairment, apparently derivative of the small airway disease in relation to Claimant's work capacity. The nexus he asserted between Claimant's coal dust exposure and the pneumoconiosis which he diagnosed and the pulmonary impairment which he noted was unclear and not persuasively explained.

Dr. Baker, on the other hand, recorded normal pulmonary function tests, but abnormal arterial blood gas studies reflecting mild resting arterial hypoxemia and moderate hypercarbia. The integrity of his blood gas study, which produced an apparently aberrational pCO_2 value upon which his finding of hypoxemia was based, was questioned by Dr. Vuskovich as the consequence of possibly defective equipment. Dr. Baker opined that Claimant had a Class 1 impairment, which, however, was undefined beyond reference to the source of the standard, the *Guides to the Evaluation of Permanent Impairment*. The reference to the FEV_1 and vital capacity being greater than 80% of predicted, however, does not suggest a severe impairment, especially in light of Dr. Simpao's assessment of a mild impairment from a different cause, and normal spirometry. Dr. Baker also explicitly relied upon a recommendation from the same source that further coal dust exposure be avoided as being totally disabling, which it is not under applicable law. *See Zimmerman v. Director, OWCP*, 871 F.2d 564, 567, 12 B.LL.R. 2-254, 2-258 (6th Cir. 1989); *White v. New White Coal Co*., 23 B.L.R. 1-1 (2004); *Taylor v. Evan & Gambrel Co*., 12 B.L.R. 1-83 (1988). The reasoning in Dr. Baker's opinion, and its relation to the underlying data, which was sparser than that relied upon by Dr. Rosenberg, is not sufficiently persuasive, by itself, or in conjunction with Dr. Simpao's opinion, to establish either the existence of coal workers' pneumoconiosis or a totally disabling pulmonary impairment attributable thereto. Thus, neither the x-ray evidence nor the best reasoned opinions of physicians, considered in the context of the record as a whole, establish the existence of pneumoconiosis or total disability caused by pneumoconiosis.

Pneumoconiosis from Employment

If a miner has pneumoconiosis and was employed in coal mines for ten years or more, he is entitled pursuant to § 718.203(b) to invoke a rebuttable presumption that the pneumoconiosis was caused by the coal mining employment. In the present case, Claimant's Social Security Earnings records, Claimant's deposition testimony, and Claimant's testimony at the formal hearing all establish a history of employment in coal mines of approximately twenty-seven years, which would allow him to invoke the rebuttable presumption that his pneumoconiosis, if its existence were proved, arose from his coal mining employment. Claimant, however, has not proved the existence of pneumoconiosis which would allow him to invoke the presumption.

Total Disability

Claimant has not proved that he is totally disabled under the Act. Under the regulations, a miner is totally disabled if, in the absence of contrary probative evidence, (1) he has qualifying pulmonary function test results, (2) he has qualifying arterial blood gas test results, (3) he has pneumoconiosis and is suffering from cor pulmonale with right-sided congestive heart failure, or (4) a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that his respiratory or pulmonary condition

prevents him from performing his usual coal mine work or work requiring skills comparable to those of any employment in a mine in which he previously engaged with some regularity over a substantial period of time. § 718.204 (b)(2).

In the present case, Claimant underwent pulmonary function tests and arterial blood gas tests on three occasions: with Dr. Baker on April 10, 2002, with Dr. Simpao on February 12, 2002, and with Dr. Rosenberg on June 14, 2004, and March 7, 2002. In each case the results of both tests were non-qualifying under the applicable federal criteria. The record contains no evidence that Claimant has cor pulmonale with right-sided congestive heart failure. Because Claimant has not established the presence of a totally disabling respiratory or pulmonary impairment through his pulmonary function tests or arterial blood gas studies, he must rely on the medical opinions of record to establish such impairment. § 718.204(b)(2)(iv). The medical opinions of record do not establish total disability.

A medical opinion that is unreasoned and undocumented may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (en banc). A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data that the physician relied on for his diagnosis. *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987). A "reasoned" opinion is one where the administrative law judge finds underlying documentation and data adequate to support the physician's conclusions. *Id.* As indicated above, both Dr. Rosenberg and Dr. Broudy gave reasoned opinions that Claimant is not totally disabled by pneumoconiosis. Dr. Broudy concluded that Claimant retains the respiratory capacity to do the arduous manual labor of a coal miner, based on the lack of physical symptoms on examination and normal spirometry and arterial blood gas test results.

Dr. Baker found that Claimant was totally disabled under applicable criteria because of Claimant's need to avoid further dust exposure. However, an opinion which recommends against further coal mine exposure because of a pulmonary disease or condition is not, as a matter of law, a finding of inability to do the work or of disability attributable to that disease. *See Zimmerman v. Director, OWCP*, 871 F.2d 564, 567, 12 BLR 2-254, 2-258 (6th Cir. 1989); *White v. New White Coal Co*., 23 BLR 1-1 (2004); *Taylor v. Evans & Gambrel Co., Inc*., 12 BLR 1-83 (1988). Dr. Baker did not opine that Claimant was totally disabled from work in a nondusty environment and did not establish that Claimant would be incapable of performing work comparable to that of his last coal mine employment. He did not address the specifics of the Class 1 impairment he identified or establish that it would be totally disabling despite its apparently limited and mild manifestations. Dr. Baker did not address the specifics of that work or disclose familiarity with it, and he did not compare the exertional requirements of that work with the Claimant's particular limitations or the Class 1 impairment criteria to which he referred. Thus, Dr. Baker's conclusion was not tantamount to a finding of total disability or probative of such disability. *See Zimmerman, supra; Taylor, supra*.

Dr. Simpao's diagnosis of small airways disease causing a "mild impairment" related to multiple years of coal dust exposure, apparently based on pulmonary function testing, x-ray, and EKG, "along with physical findings and symptomatology," which included normal arterial blood gas studies, amounts to a list of what he apparently considered, without providing any indication of how these various factors were weighed in relation to his conclusion of total

disability, especially in light of the normal blood gas test results and apparently mild impairment associated with the small airways disease assessed as a result of his pulmonary function studies. An x-ray is usually not indicative of any particular level of impairment. Thus, although Dr. Simpao identified various objective evidence in the course of his examination and report, such as Claimant's chest x-ray, symptomatology, and physical findings during examination, no particular symptoms or physical findings were cited as indicia of total pulmonary impairment or disability. Dr. Simpao never explained the basis for his conclusions, so that his opinion is essentially unreasoned, both as to the existence of pneumoconiosis and as to total disability which might be attributed to it. Thus, the totality of the evidence considered in the context of the record as a whole does not establish that Claimant is totally disabled due to pneumoconiosis.

ORDER

The claim of Charles A Morgan for Black Lung benefits under the Act is denied.[8]

A
Edward Terhune Miller
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, NW, Room N-2117, Washington, D.C. 20001.

[8] The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits charging any fee to Claimant for representation services rendered to him in pursuit of his claim.